MARYLAND HEALTH QUALITY AND COST COUNCIL

Meeting Minutes
Monday, March 18

Members in Attendance: Secretary Joshua Sharfstein (Vice Chair), James Chesley, Richard Davis, Barbara Epke, Nikki Highsmith-Vernick, Peggy O'Kane (via phone), Marcos Pesquera, Albert Reece, Jon Shematek, Kathleen White, and Christine Wray

Members Absent: Lieutenant Governor Anthony Brown (Chair), Jill Berger, Lisa Cooper, Roger Merrill

Welcome and Approval of Minutes

Secretary Sharfstein called the meeting to order at 9:33am. He welcomed the Council members and guests to the meeting and announced that the Lieutenant Governor was unable to attend. Minutes from the December 9, 2012 Council meeting were approved.

Wellness and Prevention Workgroup: Million Hearts and Other Initiatives – *Christine Wray*

Christine Wray updated the Council on ongoing efforts of the Wellness and Prevention Workgroup. About 360 people attended the Million Hearts Symposium, including 6 Council members, Ms. Wray stated. There were three "streams" at the meeting: health care, work site, and schools/child care. A survey indicated that participants left the meeting with a full understanding of the campaign and its strategies. The Department of Health and Mental Hygiene (DHMH) will continue to recruit new partners, disseminate implementation materials and resources, and promote quality improvement and value-based insurance design strategies as part of the Million Hearts campaign.

Ms. Wray then briefed the Council on the Centers for Disease Control and Prevention (CDC) Chronic Disease grant application being prepared by DHMH. The grant is prescriptive and does not a lot allow for a lot of flexibility, but does fit in with goals of Million Hearts and Maryland's Healthiest Businesses. It is a five year grant that supports statewide implementation of cross-cutting approaches that address:

- Obesity, heart disease, stroke, and diabetes
- Health promotion and prevention
- Risk factor modification
- Disease management

Prioritized strategies outlined in four chronic disease prevention and health promotion domains:

- Epidemiology and surveillance
- Environmental approaches that promote health
- Health system interventions
- Clinical-community linkages

Dr. Laura Herrera, Deputy Secretary for Public Health at DHMH, stated that this grant is a key opportunity to align public health initiatives with larger delivery system reform efforts.

Cultural Competency Workgroup –*Marcos Pesquera*

Marcos Pesquera reviewed the workgroup's tasks as required in the Maryland Health Improvement and Disparities Reduction Act of 2012. There are:

1. Examine appropriate standards for cultural and linguistic competency for medical and behavioral health treatment and the feasibility and desirability of incorporating these standards into reporting by health care providers and tiering of reimbursement rates by payors;

2. Assess the feasibility of and develop recommendations for criteria and standards establishing multicultural health care equity and assessment programs for the Maryland Patient Centered Medical Home program and other health care settings; and

3. Recommend criteria for health care providers in Maryland to receive continuing education in multicultural health care, including cultural competency and health literacy training.

Subcommittees have been formed around each task, and these groups have been meeting in recent months to begin the process of developing recommendations. Each subcommittee has a work plan, co-leaders from outside DHMH, and staff from either DHMH or the Maryland Health Care Commission (MHCC). Mr. Pesquera said he is confident they have the right people at the table.

Barbara Epke noted that there are lots of existing standards for cultural competency and asked if they were planning to seek funding for subcommittee #3. Carlessia Hussein, Director of the Office of Minority Health and Health Disparities at DHMH, indicated that her office is working on identifying funding.

Dr. Herrera asked if they were also considering other medical home programs as part of task #2, in addition to the Maryland Patient Centered Medical Home program. She noted the importance of including carrier-specific programs. Mr. Pesquera indicated that they would reach out to those programs.

Health Enterprise Zones – *Carlessia Hussein*

Dr. Hussein provided an update on the Health Enterprise Zone initiative. The Maryland Health Improvement and Disparities Reduction Act of 2012 established a process whereby the DHMH Secretary, in collaboration with the Community Health Resources Commission, would designate Health Enterprise Zones (HEZ). The purpose of these zones is to reduce health disparities, improve health outcomes, and reduce health costs and hospital admissions and readmissions in specific areas of the State. The bill contains several possible incentives that can be utilized to address disparities. HEZs must meet eligibility criteria, including economic disadvantage and poor health outcomes.

There were 13 selection principles, including sustainability, which was considered very important. A total of 19 applications were received, and 5 HEZs, listed below, were designated in January 2013. Dr. Hussein provided a description on each of the 5 zones.

- MedStar St. Mary's Hospital, "Greater Lexington Park"
- Dorchester County Health Department, "Competent Care Connections"
- Prince George's Health Department
- Anne Arundel Health System
- Bon Secours Baltimore Health System/ West Baltimore Primary Care Access Collaborative

Dr. Hussein recognized Albert Reece for his leadership is developing the initiative. Barbara Epke recognized Chris Wray for her role in the development of the St. Mary's HEZ.

Jon Shematek asked how providers will be recruited. Dr. Hussein said that they are working directly with each project to develop a recruitment strategy. Chris Wray said that they have several provider organizations as partners. They have recruited a psychiatrist, who will be the only psychiatrist in the county. One physician in the county will be providing additional time. The MedStar affiliation has helped them with recruitment.

Dr. Reece noted his concerns about the number of providers that will be required to achieve the outcomes mentioned in the proposals. Dr. Hussein said they are currently working with the zones and will make adjustments as needed. Secretary Sharfstein said that it is important to realize how different the projects are in their scope and focus. The Anne Arundel HEZ is small and contained in one housing project.

Nikki Highsmith-Vernick asked if the sites collecting data on race/ethnicity and outcomes by race. Dr. Hussein said that they are working with the zones on data collection issues and will collect race/ethnicity data. Secretary Sharfstein noted that it is incorrect to think about disparities within the HEZs; they are homogenous and contribute to county- and state-level disparities.

Mr. Pesquera asked about the status of high-quality applications were not funded. Secretary Sharfstein said that DHMH is currently identifying other funding avenues.

James Chesley said he had concerns similar to Dr. Reece. He asked if the providers are new to the area or if they are existing providers that will be dedicated their time.

Dr. Hussein said it varies; some will be part-time HEZ providers while other will be new, full-time HEZs. Secretary Sharfstein noted that the coalitions are aligning existing resources and adding new providers.

Community Integrated Medical Home – *Karen Matsuoka*

Karen Matsuoka, Director of the Health Systems and Infrastructure Administration at DHMH, provided an overview of the State Innovation Model (SIM) and the Community Integrated Medical Home (CIMH). Maryland received $2.4 million from the Center for Medicare and Medicaid Innovation (CMMI) at the Centers for Medicare and Medicaid Services (CMS) to engage in a planning process to develop the CIMH model. This model of care will integrate patient-centered medical care with community-based resources while enhancing the capacity of local health entities to monitor and improve the health of individuals and their communities as a whole.

Through a stakeholder engagement process, DHMH will develop the details of the model and devise an innovation plan to guide its implementation. A payer and provider engagement process will be used to develop programmatic standards and administrative structures for the CIMH. Second, local health improvement coalitions (LHICs), which are panels of local health departments, hospitals, physicians, community organizations, and other local entities, will be engaged to develop plans for the integration of community health with medical care and building capacities at the local level for health planning and hot-spotting of areas with inefficient use of health services. The stakeholder panels for these two processes will be named in April.

Near the end of the six-month funding period, a summit will be held to finalize policy decisions from the dual processes and development a comprehensive innovation plan. This plan will form the basis of a subsequent proposal to CMMI to fund the implementation of the CIMH model over a 4-year period.

Ms. Epke said the CIMH model aligns well with the state readmissions program. She would like DHMH to work with the Quality Council at the Maryland Hospital Association.

Ms. Highsmith-Vernick congratulated DHMH for the award and noted that she reviewed the Model Testing proposals as part of SIM. She noted that CMS will define populations around Medicaid, but that the resources need to go beyond to the broader population. Dr. Matsuoka said that the model is intended to be multi-payer.

Dr. Reece said DHMH should consider setting up a series of outcomes score cards to track all these initiatives. It would force us to evaluate progress regularly and across multiple initiatives. This would help measure and market our success. Dr. Herrera noted that DHMH is trying to identify common measures across accountable care organizations, medical homes, and other models. Dr. Reece said that would be very helpful for everyone working in health care delivery. Ms. Wray agreed, saying that whenever possible, we should use the same measures. Secretary Sharfstein noted that the State Health Improvement Process (SHIP) is an attempt to have cross-cutting measures, and StateStat also accomplishes this at a state-wide level. Dr. Kathleen White noted that NQF has a population health workgroup working on measure alignment. Ms. Epke said that that another consideration is the integrity of the data and that auditing is key.

Evidence-Based Medicine Workgroup: Value-Based Insurance Design – *Peggy O'Kane and Laura Herrera*

Peggy O'Kane thanked DHMH staff for their work on value-based insurance design (VBID) and introduced Dr. Herrera. Dr. Herrera gave an overview of VBID and reviewed efforts to date by the Council to promote VBID. She then presented a strategy for moving VBID forward in Maryland. The strategy includes the follow components:

Horizon scan	Identify state employee health plans and other large employer health plans that use VBID, with special focus on value-based designs currently being used in Maryland
	Cross-walk plans to identify most common services addressed and incentives utilized
Compare to evidence base	Identify quality studies of effect of VBID on utilization/spending and quality of care/health outcomes.
	Compare cross-walk of most common services and incentives to evidence base on VBID effectiveness
	Develop list of most promising services to address and incentives to utilize
Develop VBID criteria and designation levels	Based on evidence comparison described above, develop a set of criteria for what qualifies as VBID in Maryland. This should include different levels of VBID designation for qualified health plans in the Maryland Health Benefits Exchange, as well as non-Exchange plans. Identify any Maryland health plans that already meet criteria.
Develop strategy for VBID and PCMH integration	When used in tandem, VBID and patient-centered medical home (PCMH) models have a synergistic relationship; incentives to use the highest-value services are aligned for patients and their providers.
	Develop a strategy for integrating VBID into Maryland's Community-Integrated Medical Home (CIMH), a new state-wide, multi-payer PCMH program in the early planning stages.

Dr. Herrera asked the Council for feedback on the strategy. Ms. Highsmith-Vernick noted the importance of how this is pitched. If done poorly, VBID may come across as rationing.

Secretary Sharfstein stated that there is a need to think about the intersection with the Maryland Health Benefits Exchange. He said the Council could make a recommendation about designation levels, and the Exchange would then adopt the policy. The Maryland Insurance Administration would have to sign off on the plan designs.

He also noted that it may not be possible to accomplish this before January 2015; we may need to focus on January 2016. He also noted that the Exchange Board of Directors is aware and generally supportive of this work.

Dr. Herrera noted that existing health plans have value based benefits and that we need identify them as part of this effort. She also said that we will consider provider networks in addition to just services.

Dr. Chesley said that he is excited about VBID but that we need to have a proviso to protect patients.

Dr. Sharstein noted that MHCC will be involved in this work moving forward.

Anne Timmons, who oversees the state employee health plans for the Department of Budget and Management, said that the timing is aligned very well to include VBID in state employee plans. A request for proposals (RFP) will be released in early fall for a new round of employee plans. These plans will go live in January 2015.

Adjournment

Dr. Sharstein asked if any Council members had further questions or comments before adjournment.

Ms. Epke said that she wanted to point out that hospitals have made progress on the Hand Hygiene Initiative. Many hospitals are over 90 percent compliance at this point. She asked if the Council would like the Evidence-Based Medicine workgroup to address more "quick hit" projects in the hospital setting. She specifically mentioned Clostridium difficile (C. diff) infection. Dr. Sharstein said that if there are places where we can develop quick projects we should.

Academic detailing around prescription drugs was also raised as a potential project, as there are clearly some areas of excess cost in the prescription drugs space. This hasn't emerged into a state project yet, but it may be possible to achieve some short term progress. Ms. Epke said that hospitals are doing this and it would be great to have a coordinated effort.

The meeting was adjourned at 11:13am.